

Facility Name & ID Number Astoria Gardens & Rehab Center

0045849 Report Period Beginning: 1/1/09 Ending: 12/31/09

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 4/1/09

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>67</u>	Skilled (SNF)	<u>57</u>	<u>21,705</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>67</u>	TOTALS	<u>57</u>	<u>21,705</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	<u>7,608</u>	<u>3,650</u>	<u>2,226</u>	<u>13,484</u>		8
9	SNF/PED						9
10	ICF						10
11	ICF/DD						11
12	SC						12
13	DD 16 OR LESS						13
14	TOTALS	<u>7,608</u>	<u>3,650</u>	<u>2,226</u>	<u>13,484</u>		14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.12%

D. How many bed-hold days during this year were paid by the Department? 223 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 08/01/02

J. Was the facility purchased or leased after January 1, 1978?
YES Date 8/1/02 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 57 and days of care provided 1,881

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 1/1/09 Fiscal Year: 12/31/09

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Astoria Gardens & Rehab Center # 0045849 Report Period Beginning: 1/1/09 Ending: 12/31/09

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	85,382	10,392	4,812	100,586		100,586		100,586		1
2	Food Purchase		68,489		68,489		68,489		68,489		2
3	Housekeeping	25,722	6,379		32,101		32,101		32,101		3
4	Laundry	24,088	3,514		27,602		27,602		27,602		4
5	Heat and Other Utilities			62,578	62,578		62,578	(1,521)	61,057		5
6	Maintenance	18,003	262	42,615	60,880		60,880		60,880		6
7	Other (specify):*										7
8	TOTAL General Services	153,195	89,036	110,005	352,236		352,236	(1,521)	350,715		8
	B. Health Care and Programs										
9	Medical Director			2,250	2,250		2,250		2,250		9
10	Nursing and Medical Records	531,393	105,212	11,644	648,249		648,249		648,249		10
10a	Therapy	102,352		25,622	127,974		127,974		127,974		10a
11	Activities	19,365	247	767	20,379		20,379		20,379		11
12	Social Services	28,405		547	28,952		28,952		28,952		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	681,515	105,459	40,830	827,804		827,804		827,804		16
	C. General Administration										
17	Administrative	61,532		(345)	61,187		61,187		61,187		17
18	Directors Fees										18
19	Professional Services			19,949	19,949		19,949		19,949		19
20	Dues, Fees, Subscriptions & Promotions			5,619	5,619		5,619	(1,893)	3,726		20
21	Clerical & General Office Expenses	36,489	10,453	95,988	142,930		142,930	(3,047)	139,883		21
22	Employee Benefits & Payroll Taxes			163,995	163,995		163,995		163,995		22
23	Inservice Training & Education			3,850	3,850		3,850		3,850		23
24	Travel and Seminar			10,410	10,410		10,410	(629)	9,781		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			40,322	40,322		40,322		40,322		26
27	Other (specify):*										27
28	TOTAL General Administration	98,021	10,453	339,788	448,262		448,262	(5,569)	442,693		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	932,731	204,948	490,623	1,628,302		1,628,302	(7,090)	1,621,212		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Astoria Gardens & Rehab Center

#0045849

Report Period Beginning:

1/1/09

Ending:

12/31/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			12,720	12,720		12,720	76,182	88,902			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,789	30,789		30,789	48,248	79,037			32
33	Real Estate Taxes			31,386	31,386		31,386		31,386			33
34	Rent-Facility & Grounds			144,000	144,000		144,000	(144,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Corp. Tax			1,341	1,341		1,341		1,341			36
37	TOTAL Ownership			220,236	220,236		220,236	(19,570)	200,666			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,558	32,558		32,558		32,558			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			32,558	32,558		32,558		32,558			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	932,731	204,948	743,417	1,881,096		1,881,096	(26,660)	1,854,436			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Astoria Gardens & Rehab Center

ID# 0045849

Report Period Beginning: 1/1/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Marketing	\$	(3,047)	21
2				
3				
4				
5				
6				
7				
8				
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43				
44				
45				
46				
47				
48				
49	Total		(3,047)	

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Astoria Gardens & Rehab Center# 0045849

Report Period Beginning:

1/1/09

Ending:

12/31/09

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(1,521)	0	0	0	0	0	0	0	0	0	0	(1,521)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,521)	0	(1,521)	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,893)	0	0	0	0	0	0	0	0	0	0	(1,893)	20
21	Clerical & General Office Expenses	(3,047)	0	0	0	0	0	0	0	0	0	0	(3,047)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(629)	0	0	0	0	0	0	0	0	0	0	(629)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(5,569)	0	(5,569)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(7,090)	0	(7,090)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Astoria Gardens & Rehab Center# 0045849

Report Period Beginning:

1/1/09

Ending:

12/31/09

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	15,199	60,983	0	0	0	0	0	0	0	0	0	76,182	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,754)	51,002	0	0	0	0	0	0	0	0	0	48,248	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(144,000)	0	0	0	0	0	0	0	0	0	(144,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	12,445	(32,015)	0	(19,570)	37								
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	5,355	(32,015)	0	(26,660)	45								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Steve Axelbaum	50			Astoria Gardens LLC	Astoria	Real Estate
Jan Axelbaum	50					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Building/Equipment Rental	\$ 144,000	Astoria Gardens LLC	100.00%	\$	(144,000)	1
2	V	32 Interest			100.00%	51,002	51,002	2
3	V	30 Depreciation			100.00%	60,983	60,983	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 144,000			\$ 111,985	\$ * (32,015)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Astoria Gardens & Rehab Center # 0045849 Report Period Beginning: 1/1/09 Ending: 12/31/09

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Steve Axelbaum	President	Administrator	50.00		40	100.00	w-2 wage	\$ 19,627	17-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 19,627		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Astoria Gardens & Rehab Center

0045849

Report Period Beginning:

1/1/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Astoria Gardens & Rehab Center

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Ending:

12/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	US Bank	x		Mortgage	\$7,754.00	10/10/08	\$	\$	2/10/09	4.2500	\$ 4,286	1							
2	US Bank	x		Mortgage	\$7,754.00	2/10/09			8/10/09	4.2500	23,612	2							
3	US Bank	x		Mortgage	\$7,754.00	8/10/09			1/10/10	5.2500	23,104	3							
4												4							
5												5							
Working Capital																			
6	Investment Group, Vendors,	x		Operations							28,035	6							
7	Insurance Installments, credit											7							
8	cards, owner											8							
9	TOTAL Facility Related				\$23,262.00		\$	\$			\$ 79,037	9							
B. Non-Facility Related*																			
10	IHFS Late Penalty										2,754	10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ 2,754	14							
15	TOTALS (line 9+line14)						\$	\$			\$ 81,791	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.		\$	30,319	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	30,874	2
3. Under or (over) accrual (line 2 minus line 1).		\$	555	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	31,386	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	31,941	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	29,294	8	
	2005	29,602	9	
	2006	30,851	10	
	2007	30,363	11	
	2008	30,874	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

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0045849

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,608 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Astoria Gardens & Rehab Center

0045849

Report Period Beginning:

1/1/09

Ending:

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XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	57	2002		\$ 1,300,000	\$ 60,983	27.5	\$ 60,983	\$	\$ 389,768	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Underground Wiring for Lamp Post	2002		1,151	30	39	30		635	9
10	Bathroom Fixtures	2004		3,580	511	7	511		2,514	10
11	Carpet	2004		243	35	7	35		171	11
12	Floor Tile	2004		1,093	156	7	156		754	12
13	Remodeling	2004		19,524	1,302	15	1,302		6,075	13
14	Public Health Modifications (fire walks & ceiling tiles)	2004		15,727	1,048	15	1,048		4,446	14
15	Widespread Faucet	2005		116	17	7	17		66	15
16	2 Fire Doors	2005		1,127	41	27.5	41		150	16
17	Storage Building	2005		8,640	314	27.5	314		968	17
18	Concrete Patio	2008		773	77	10	77		154	18
19	Driveway	2008		3,695	370	10	370		740	19
20	Fences	2008		4,975	498	10	498		996	20
21	North Hall Ceiling	2008		1,824	182	10	182		364	21
22	Light Fixtures	2008		609	61	10	61		122	22
23	4 Lavatories	2008		343	34	10	34		68	23
24	3 Showers	2008		291	29	10	29		58	24
25										25
26	Doors & Trim	2008		5,686	569	10	569		1,138	26
27	Wallpaper	2008		2,428	243	10	243		486	27
28	Flooring	2008		10,240	1,024	10	1,024		2,048	28
29										29
30	Doors & Trim	2008		1,796	180	10	180		360	30
31	Flooring	2008		934	93	10	93		186	31
32										32
33	Paint & Labor	2008		4,833	483	10	483		966	33
34	Construction Manager	2008		12,013	1,201	10	1,201		2,402	34
35	Plywood, Putty, mortar and stain	2008		1,725	173	10	173		346	35
36	Engraved Door Nameplates & Numbers	2008		175	18	10	18		36	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Astoria Gardens & Rehab Center

0045849

Report Period Beginning:

1/1/09

Ending:

12/31/09

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Plumbing for six rooms	2008	\$ 3727.93	\$ 373	10	\$ 373	\$	\$ 746	37
38	Electrical work for six rooms	2008	3359.15	336	10	336		672	38
39	Air conditions for therapy room	2008	1561.75	156	10	156		312	39
40	Sprinkler heads & installation	2008	1195	120	10	120		240	40
41	Wallpaper labor	2008	1201.17	120	10	120		240	41
42	Hallway ceiling & grid	2008	1095.19	110	10	110		220	42
43	Electrical work for laundry room	2008	2756.25	276	10	276		552	43
44	Drywall, tape, nails, screws, etc	2008	1640.41	164	10	164		328	44
45	Shower repairs	2008	195	20	10	20		40	45
46	Stained glass & shower curtains	2008	601	60	10	60		120	46
47	Move sink in laundry room	2008	384.03	38	10	38		76	47
48	Plumbing for therapy kitchen	2008	1323.19	132	10	132		264	48
49	Construction manager	2008	699.06	70	10	70		140	49
50	Cabinets & countertops for therapy kitchen	2008	1233.43	123	10	123		246	50
51	Vanity, mirror & bathroom fixtures	2008	484.23	48	10	48		96	51
52	Therapy room tiling	2008	300.24	30	10	30		60	52
53	Garden fountain	2008	171.33	17	10	17		34	53
54	Draperies	2008	3234	323	10	323		646	54
55	Tablecloths	2008	51	5	10	5		10	55
56	Draperies and Blinds	2008	1,867	187	10	187		374	56
57	Shower room door	2009	689	69	10	69		69	57
58	North Wing fire doors	2009	1,921	192	10	192		192	58
59	Linoleum for rooms, restrooms	2009	1,773	177	10	177		177	59
60	New Sidewalk	2009	3,500	350	10	350		350	60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,438,504	\$ 73,167		\$ 73,167	\$	\$ 422,220	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Astoria Gardens & Rehab Center

0045849

Report Period Beginning:

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Ending:

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XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 100,838	\$ 10,084	\$ 10,084	\$		\$ 71,063	71
72	Current Year Purchases	49,024	4,902	4,902			4,902	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 149,862	\$ 14,986	\$ 14,986	\$		\$ 75,965	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Maintenance & Errands	1988 Ford Club Wagon	2003	\$ 3,000	\$	\$	\$		\$ 3,000	76
77	Resident Transportation	1999 Chevy Van	2006	3,743	749	749			2,621	77
78										78
79										79
80	TOTALS			\$ 6,743	\$ 749	\$ 749	\$		\$ 5,621	80

E. Summary of Care-Related Assets

	1	2		
	Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,595,109	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 88,902	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 88,902	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 503,806	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Sidewalk to barn 2004	\$ 5,068	\$ 130	\$ 791	86
87	Drive for barn 2004	440	29	177	87
88	Barn Fence 2004	780	52	295	88
89	Completion of barn 2004	348	23	131	89
90		3,311	85	481	90
91	TOTALS	\$ 9,947	\$ 319	\$ 1,875	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Astoria Gardens LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		<u>57</u>	<u>8/1/02</u>	\$ <u>144,000</u>	<u>6</u>	<u>10</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		<u>57</u>		\$ <u>144,000</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>/2010</u>	\$ <u>144,000</u>
13.	<u>/2011</u>	\$ _____
14.	<u>/2012</u>	\$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	102.5 hrs	\$ 9,750		\$		103	\$ 9,750	1
2	Licensed Speech and Language Development Therapist	10a-3	27 hrs	1,900				27	1,900	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	126 hrs	12,803				126	12,803	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$ 24,453		\$	\$	256	\$ 24,453	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Astoria Gardens & Rehab Center

0045849

Report Period Beginning: 1/1/09

Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 15,172	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	339,003		3
4	Supply Inventory (priced at)	10,088		4
5	Short-Term Investments			5
6	Prepaid Insurance	7,963		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	4,442		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 376,668	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	148,497		15
16	Equipment, at Historical Cost	157,506		16
17	Accumulated Depreciation (book methods)	(80,467)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 225,536	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 602,204	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 205,255	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,700		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	47,973		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,874		32
33	Accrued Interest Payable	3,898		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Due to Related Party</u>	186,741		36
37	<u>Accrued State Assessment</u>	7,866		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 484,307	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	49,527		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 49,527	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 533,834	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 68,370	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 602,204	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (113,277)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (113,277)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	181,644	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 181,644	17
	B. Transfers (Itemize):		
18	rounding	3	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 3	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 68,370	24 *

* This must agree with page 17, line 47.

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0045849

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,306,994	1
2	Discounts and Allowances for all Levels	(567,151)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,739,843	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	240,203	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 240,203	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	60	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 60	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	699	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 699	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	81,935	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 81,935	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,062,740	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	352,236	31
32	Health Care	827,804	32
33	General Administration	448,262	33
B. Capital Expense			
34	Ownership	220,236	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	32,558	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,881,096	40
41	Income before Income Taxes (line 30 minus line 40)**	181,644	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 181,644	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,884	1,981	\$ 53,479	\$ 27.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,315	3,470	75,694	21.81	3
4	Licensed Practical Nurses	6,022	6,226	116,262	18.67	4
5	CNAs & Orderlies	26,140	27,794	264,402	9.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,837	1,920	19,365	10.09	9
10	Activity Assistants					10
11	Social Service Workers	2,728	2,792	28,405	10.17	11
12	Dietician					12
13	Food Service Supervisor	242	242	2,650	10.95	13
14	Head Cook	5,646	5,908	49,103	8.31	14
15	Cook Helpers/Assistants	3,963	4,069	33,628	8.26	15
16	Dishwashers					16
17	Maintenance Workers	1,479	1,520	18,003	11.84	17
18	Housekeepers	2,912	3,076	25,722	8.36	18
19	Laundry	2,653	2,811	24,088	8.57	19
20	Administrator	2,080	2,080	19,627	9.44	20
21	Assistant Administrator	2,080	2,080	41,905	20.15	21
22	Other Administrative	529	565	6,797	12.03	22
23	Office Manager	2,080	2,120	29,693	14.01	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care therapists	3,337	3,360	102,287	30.44	32
33	Other(specify) <u>care plan coord</u>	1,056	1,114	21,621	19.41	33
34	TOTAL (lines 1 - 33)	69,983	73,128	\$ 932,731 *	\$ 12.75	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	90	\$ 4,641	1-3	35
36	Medical Director		2,250	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,706	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		657	11-3	44
45	Social Service Consultant		657	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	90	\$ 13,911		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses				50
51	Licensed Practical Nurses	135	5,154	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	135	\$ 5,154		53

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Ending: 12/31/09

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? no
If YES, give association name and amount. n/a
- (3) Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? n/a
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? _____ If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,449 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 32,558
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ n/a Has any meal income been offset against related costs? n/a Indicate the amount. \$ n/a
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ n/a
c. What percent of all travel expense relates to transportation of nurses and patients? n/a
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ n/a
- (17) Has an audit been performed by an independent certified public accounting firm? no
Firm Name: n/a
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? n/a
Attach invoices and a summary of services for all architect and appraisal fees.